DOCUMENT RESUME

ED 153 160 CG 012 517

AUTHOR Hartigan, Kevin J.; Weiskott, Gerald N.
TITLE Depression: What It Is and How to Deal With It: A Manual.
PUB DATE [76]
NOTE 37p.

EDRS PRICE MF-$0.83 HC-$2.06 Plus Postage.
DESCRIPTORS *Behavior Problems; College Students; *Depression (Psychology); *Emotional Adjustment; *Group Counseling; Guides; Higher Education; *Psychopathology; Theories; *Workshops

ABSTRACT

This manual is designed to help counseling personnel understand and deal with depression. It begins by defining depression (the "common cold of psychopathology") and listing a number of typical symptoms, giving mild, moderate and severe manifestations. It then offers seven different treatment approaches or theories. Directly or indirectly, these theories most frequently account for negative expectancy, dejected mood, behavioral deficits, retarded physical activity, loss of libido and appetite and activational deficits. A majority of the theories acknowledge faulty cognitions, passivity and avoidance as manifestations of depression. The manual concludes by outlining a workshop designed to help college students manage depression and stress. The workshop (two sessions of three hours each) is not intended to replace individual therapy but can be used as a productive adjunct to it. (Author/BL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED153160

Depression: What It Is and How To Deal With It

A Manual

Kevin J. Hartigan Gerald N. Weiskott

The Ohio State University
Counseling and Consultation Service

U.S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

G. N. Weiskott

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

CG 012 517

Not to be reproduced without permission

Depression: What It Is and How To Deal With It
A Manual*

Kevin J. Hartigan Ohio State University Gerald N. Weiskott

Depression is the "common cold of psychopathology" (Beck, 1967). Millions of people, both in and out of mental institutions, are affected by it. No one is immune from depression. While it appears to be unavoidable, it is perhaps the most disruptive influence in many peoples' lives in that it is usually connected with loss, stress, failure, and/or a sense of hopelessness.

Although it has been recognized as a clinical syndrome for over 2,000 years, very little is known about the causes of depression. Some have labelled it a disease (Kraeplin, 1913), having its roots in the dysfunction of the viscera or other physiological mechanisms. Others suggest that the etiology of depression lies with altered cognitive, perceptual or mood states, which then have a debilitative impact on behavior (Meyer, 1908). To add to the confusion, some researchers and clinicians recognize depression only as a functional part of a large disorder such as schizophrenia, while others insist that it is an entity in itself.

In spite of this uncertainty, most people involved in the study of depression more or less agree that it is typically manifested by the presence of certain symptoms. Most will readily and accurately recognize depression, given a particular set of symptoms. For the

purposes of this manual, depression will be viewed as an affective disorder rather than as a disease and will be defined in terms of its symptoms. While there are different types of depression, we will restrict ourselves to reactive depression, which is defined as a qualitative lowering (beneath a baseline level) of the affective state as the result of some real or perceived stress present in the environment. Depressions of this sort appear to be highly related to a sense of personal loss and may be generalized to other areas within the person's phenomenal field. Reactive depression has emotional, cognitive, motivational, and physiological manifestations which are briefly outlined in the tables below. All symptoms are aligned along a continuum ranging from mild to severe. For additional information regarding the symptoms of depression, the reader is referred to Beck (1967).

SYMPTOMS OF DEPRESSION

1. Emotional Manifestations

The term "emotional manifestations" refers to changes in a person's feelings or changes in behavior directly attributable to feeling states.

Degree of Emotional Manifestation

Symptom	Mild	Moderate	Severe
Dejected Mood	Pt. reports feeling "blue"	Dysphoria is more pronounced	Pt. reports feelings of misery, worthlessness
Neg. feelings toward self	Disappointment in self	Stronger self-rejection	Self-hatred
Reduction in gratification	Some activities yield reduced gratification	Most activities yield reduced gratification	Aversion to formerly satisfying activities
Loss of emotional attachments	Some loss of other-orientedness	Indifference toward others	Apathy or aversion toward others
Crying spells	Increased tendency to cry	Any unpleasant situation elicits tears	Inability to cry
Loss of mirth	Failure to find jokes funny	Progressive loss of humor	No response to humor

Pt. = patient

COMMENTS:

Negative feelings toward self and reduction in gratification are cardinal symptoms of depression. The loss of emotional attachments and dejected mood are highly related to them. In depressives, the loss of a sense of humor is not a matter of an inability to detect the point of a joke (they can). Rather, the issue is that they simply do not feel like laughing.

2. Cognitive manifestations

The cognitive manifestations of depression encompass three

areas, the first of which is composed of the (1) individual's distorted attitudes toward himself, his experience and his future. (2) Self-blame is the second cognitive symptom. (3) The third centers around decision-making: depressives are apt to be vacillating and indecisive.

Degree of Cognitive Manifestation

Symptom	Mild	Moderate	Severe
Low self-evaluation	Pt. regards errors as indicative of his inadequacy	Interprets neut. events as indicative of his inadequacy	Self-attributions of worthlessness; ineptness
Negative expectations	Predilection toward neg. expectancies	Predilection is stronger	Insistence that the future is hopeless
Self-blame/ criticism	Self-blame as a result of failure to meet goals	Self-rebuke is harsher	Acceptance of blame for all misfortune in the world
Indecisiveness	Some obstructions in d-making process	Difficulty spreads to almost all decisions	Pt. believes himself incapable of making any decision at all
Distortion of Body Image	Overconcern for physical appearance	Attributions of ugliness	Attributions of physical deterioration

COMMENTS:

Low self-esteem is another cardinal symptom of depression. Self-devaluation is related to the individual's pattern of viewing himself as deficient in those attributes which are important to him, notably ability, intelligence and health. Negative expectations may be related

to the exaggerated feelings of inadequacy noted above. Many depressives "expect the worst" and simply reject the possibility that any improvement in their condition is possible. Self-blame is related to the depressive's disposition toward blaming himself for his deficiencies, perceived or real. The individual's expectation that any decision he makes will be wrong yields indecisiveness. Further, many depressives cannot garner the will or the drive to make decisions, and must rely on others to do so for them.

3. Motivational Manifestations

There is an evident decrement in motivation exhibited by depressed people, which is probably related to the cognitive and emotional deficits described above. A striking feature of this phenomenon is its regressive nature. Adults who, previous to the onset of depression, were active and energetic avoid even activities which require the least effort or personal responsibility.

Degree of Motivational Manifestations

Symptom	Mild	Moderate	Severe
Paralysis of the will	Loss of spontaneous desire to engage in some activities	Loss of desire spreads to include more activities	No desire to do anything
Avoidance wishes	Inclination to avoid dull or taxing activities	Inclination is stronger	Seclusiveness or withdrawal from others
Suicidal wishes	Occasional; passive in quality	More frequent and compelling	Intense, yet follow-through unlikely
Increased dependency	Pt. expresses desire to be helped	Increased requests for assistance	Extremely dependent; Pt. can do nothing for himself

COMMENTS:

As the individual becomes more depressed he attends more to internal, rather than external, cues. As a result, he is less likely to seek out activities with others, or those which are seen to be even slightly burdensome. Dependency and suicidal wishes are often associated with depression. It should be noted that severely depressed people are not as likely to commit suicide as moderately depressed individuals because the former are too regressed to carry out such a drastic action.

4. Vegetative and Physical Manifestations

The physical symptoms of depression are widely considered to comprise strong evidence for a basic autonomic or hypothalamic dysfunction correlative (or causal) to depression.

Degree of Physical Manifestation

Symptom	Mild	Moderate	Severe
Loss of appetite	Loss of enjoyment of food	Loss of desire to eat	Pt. needs to be forced to eat
Sleep disturbance	Pt. awakens ½ hr. earlier than usual	Awakens 1-2 hrs. earlier	Pt. can only get 4-5 hrs. sleep w/out medication
Loss of libido	Loss of spontaneous sexual desire	Pronounced reduction	No responsivity to sexual stimulation
Fatigability	Pt. tires more easily than usual	Tiredness upon awakening	Pt. is "too tired to do anything"

COMMENTS:

Beck (1967) suggests that for many patients the loss of appetite is the first sign of a forthcoming depression and its restoration is the first indication of relief. After several weeks of depression, a patient may exhibit dramatic weight loss due to appetite loss. Studies reveal that there is a considerable loss of Stage IV (deep) sleep, together with excessive restlessness and decrements in the total amount of sleep had by depressives. Passivity, loss of motivation and energy, and general unresponsiveness to others accounts for the drpressive's disinterest in sexual stimulation.

These then, are many of the usual signs, in gradations of severity, of depression. These are important to recognize in order to treat depression. In order to further understand depression, it seems necessary to briefly review some of the major approaches to depression.

APPROACHES TO DEPRESSION

1. Beck's Cognitive Treatment Approach

Beck's cognitive treatment of depression is derived from his theory which relates cognitions to emotional states and behavior. Basically, a "primary triad" of three major cognitive patterns yield depressive disturbances. The first component of the triad is the negative interpretation of experience. Depressed individuals are said to consistently construe interactions with the environment as representative of defeat, deprivation or inadequacy. The depressive views his life as

filled with tremendous burdens, overwhelming obstacles or traumatic situations.

The second component of the triad is the tendency to view the self in a negative manner. Depressive ideation is replete with ruminations of deficiency and blameworthiness. The depressed patient tends to attribute his unpleasant experiences to some physical, mental or moral defect in himself and hence views himself as worthless.

The third component consists of viewing the future in a negative way. He anticipates that his current difficulties will continue unresolved and that the future will be bleak. This component clearly reflects the notion of expectancy. As the individual looks to the future he anticipates continued hardship, which tends to reduce the possibility of significant adaptive behavior on his part.

Beck contended that affective states are the result of how the individual structures his experience. If a patient, for example, was rejected by an "important other" he would experience an unpleasant feeling. Similarly, if he thought he was rejected by the other person, he would experience the same negative affect. Further, if he expected rejection from the other, both negative affect and avoidance would ensue. Thus, the way the individual structures his experience determines his mood. Since the depressive engages in persistent negative conceptualizations, he is prone to experience an ongoing negative mood. In other words, the theory postulates that the depression-prone individual has idiosyncratic cognitive patterns

(schemas) which are activated by stress. The activation of these schemata results in their domination of the individual's ideation and produce the affective and motivational effects associated with depression. Beck suggests that during depressive episodes cognitive psychotherapy may be used to help the patient gain objectivity toward his automatic reactions to stimuli and counteract them. During periods of minimal depression, therapy is directed toward the modification of the idiosyncratic patterns, thereby reducing the patient's vulnerability to future depressions. To this end, Beck discusses several major therapeutic tasks which will be outlined below:

Delineating the major maladaptive patterns

In reviewing the patient's history, the therapist seeks to identify the major patterns or sequences in the patient's life. It is usually possible to demonstrate to the patient that he responds selectively to certain types of experiences. That is, he does not overreact to all unpleasant situations, but has a predilection to react excessively to certain events. The authors cite some of the more common events which tend to elicit overreaction: failure to achieve a goal or to meet some expected performance standard, rejection, not receiving expected approval and receiving criticism.

Neutralizing "automatic thoughts"

In this task the therapist has the patient focus on his specific depression-generating cognitions. Ellis (1962) refers to these as "self-statements" or "internalized verbalizations". Beck labels them "automatic thoughts" and suggests that they often lie on the periphery of the person's awareness. These thoughts reflect the distortions which

occur frequently in the depressed state. The argument is that if the patient can identify these thoughts, he will be better able to attain objectivity toward them and neutralize some of their pathogenic effects.

Identifying idiosyncratic content

Given that the depressive cognitions can be identified and their impact on the individual estimated, the therapist attempts to have the patient recognize common themes running throughout his depressive ideation. The most frequent themes which produce unpleasant affect involve self-reproach, deprivation and inferiority. Beck points out to his patients that they perseverate in only a few interpretations of events, most of which result in unpleasant feelings. He argues that there are more accurate ways to interpret experience which result in a more realistic assessment of the world and a more positive affective state.

Recognizing formal characteristics of cognitions

Here Beck distinguishes two types of thinking: a) higher level--this involves judgment, weighing of evidence and considering alternative explanations of experience (secondary process thought); b) lower level--the rapid, simple and often illogical appraisal of stimulation (primary process thought). Automatic thoughts are of the lower level, appear to be reflexive and devoid of careful deliberation or reasoning. A related effect is their involuntary quality: they often impinge on the patient's consciousness despite his will to neutralize or negate them. Beck has his patients view them as a sort of obsession which, even if bothersome,

need not be given any truth value. Because many depressed patients are convinced of the accuracy of the automatic thoughts, they are often resistant to contrary suggestions by the therapist. Severely depressed people are often given anti-depressant medication at this point to deflate their affective torment. This presumably serves to allow them to take a clearer, more objective look at their cognitions.

Distinguishing "ideas" from "facts"

The patient must be trained to assess the validity of his appraisals of events. This is centered around the distinction between thinking and believing. Most depressives need to become aware of the fact that thoughts are not equivalent to external reality and, no matter how convincing they seem, should not be accepted until/unless they are validated by some objective procedure.

Checking Observations

It is critical that patients check the accuracy of their initial impressions of a situation. They often tend to "jump to conclusions" and ignore details within a situation that are incompatible with their initial judgments. Beck makes his patients understand their hasty conclusions, detail the "facts" of the relevant situations, and upon a reexamination of the evidence, arrive at more reasonable assessments.

Responding to depressive cognitions

Once a patient can identify and neutralize destructive automatic thoughts, attention turns to the search for other ways of explaining or interpreting events. Both therapist and patient review the latter's

cognitions about a troublesome event, and suggest reasonable alternative cognitions which more closely approximate reality.

Modifying mood by induced fantasies

Many depressives have fantasies, the content of which centers around deprivation, inadequacy, unattractiveness, etc. Beck suggests that having the patient repeat the fantasies and going through the processes described above will allow for greater objectivity and a release from the gloomy mood the fantasies induce. Another way to modify mood is to have the patient recall pictorially past successes and gratifications. Finally, Beck suggests that the patient create a fantasy similar to the initial one. However, in this fantasy the patient is asked to picture himself succeeding and coping.

The therapeutic approach described above attempts to change the way the patient construes events by considering and modifying explanations and interpretations of adverse circumstances and events. Beck argues that an attenuation of negative schemata should modify patient goal-setting, expectancies and behavior.

2. SOCIAL LEARNING THEORY (SLT) APPROACHES

Depression is frequently seen in people who fail to achieve up to expectations in an important need area. Rotter (1972) suggests that "externals" (those who believe that their reinforcements are controlled by chance, fate or powerful others) are particularly difficult therapy cases. Hiroto and Seligman (1974) argue that externals are most vulnerable to depressive episodes. Rotter suggests that patients

should become increasingly internal as therapy progresses. This would particularly hold true for depression. "Social Learning Therapy" for depression would be directed along the following areas:

1) An examination of the patient's expectancies, abilities and need values. If the individual expects to attain unreachable goals, he is likely to fail and experience depression. To this end the therapist attempts to convince the patient to lower his minimum goal level. This should then increase his expectancy for goal achievement. If the patient's abilities are not sufficient to reach a goal, he either acquires those abilities through training or receives a suggestion from the therapist that he change or lower the value level of his goals.
2) Many depressives tend to have a very narrow range of goals. In this case, the therapist helps the patient broaden the types of goals he can strive for and hope to reach.
3) Therapy is directed toward having the patient learn or acquire the expectancy that frustration can be overcome by seeking alternative paths to goals.
4) The therapist attempts to instill in the patient an expectancy that directing attention to other people in a difficult situation will help suppress distressing behaviors.
5) Finally, the therapist attempts to persuade the patient that many punishments can be avoided by better discrimination of situations previously regarded as the same.

In short, the therapeutic outline offered here either a) attempts to train the patient in the requisite skills in order for him to achieve his present goals, thereby augmenting positive expectancies and motivation for adaptive responding; or b) attempts to alter the patient's "psychological situation" such that he can reasonably expect to achieve adjusted goals, thus relieving him of the depressed affective state as well as helping him cope with future depressive episodes.

3. THE EGO-ANALYTIC VIEW: JACOBSON AND BIBRING

The traditional psychoanalytic view of depression revolves around the concept of oral fixation. It is during the oral stage of development that humans are almost completely dependent on others for physical and emotional survival. Thus, the dependency so often manifested by adult depressives is said to have its origin in the frustration of successful progress through the oral stage. In addition, depression is seen as a conflict between the ego and the superego. Thus, feelings of blame-worthiness and worthlessness evident in depressed people can be accounted for--by the interaction of a weak ego with an overly rigid superego. The ego-analytic view of depression, with Jacobson (1971) and Bibring (1953) as proponents, accepts the oral roots of depression and admits that it may in part be caused by superego involvement. However, since the ego is the reality-testing mechanism in the personality, and since depressives are usually deficient in reality-related phenomena, the ego is said to be the primary unit of analysis in the consideration of depression.

In the ego-analytic perspective the basic mechanism of depression

is the ego's awareness of its helplessness or impotence with respect to its aspirations. This condition has its origins in narcissistic trauma early in life. This state is regressively reactivated later when the individual confronts situations which resemble those in early childhood. In this scheme, depression subsides when one of the following conditions are met: a) when narcissistically important goals appear once again to be within reach; b) when they are modified so as to become realizable; c) when they are totally abandoned d) when the ego recovers from "narcissistic shock" through the help of various recovery mechanisms, that is, when positive self-esteem is restored as a function of time, therapy or a degree of success relative to some important goal; or e) when defense mechanisms (e.g. apathy, hypomania, etc.) are directed against the affective thrust of depression.

Therapy is generally directed toward helping the patient achieve insight into the original event which resulted in his predisposition to depression as well as an examination of his current feelings of powerlessness. Neither Bibring (1953) nor Jacobson (1971) provide a detailed therapeutic treatment scheme.

4. KLINGER'S MOTIVATIONAL VIEW

Loss of motivation is a core problem in depression. Klinger (1975) posits incentives as the organizational focus of behavior. In his scheme, depression represents a disengagement from incentives. Two additional constructs are central to Klinger's theory. First, the state of behavioral involvement with respect to a particular goal is labelled "current concern". This construct is employed to account for the fact that an individual can continue pursuing a goal despite changes in the

environment, changes in internal drive states, as well as obstacles inhibiting goal attainment. Current concerns are said to reflect the state of the individual from the time of committment to a goal to either consummation or disengagement. The second construct is that of the "committment" of the individual to a goal or incentive, admitting that committment must be inferred as a "logically necessary antecedent of its presumed consequences" (p.4). During states of current concern individuals tend to be more responsive to concern-related stimuli than they would otherwise be. Responses to concern-related stimuli come from the individual's repertoire of incentive-related behaviors. Thus, loss or impoverishment of incentives can effect a reduced activity level. Klinger concluded that the anticipation of attaining incentives plays a crucial role in instigating, maintaining and directing goal-related behavior, thus suggesting an expectancy model of behavior.

Klinger's primary concern is the explication of an incentive-disengagement cycle to account for aggression, depression and some other pathological states. He suggests that time is the only known "cure" for depression. Otherwise, his etiological view suggests a general treatment strategy involving emotional support for the patient as well as an "educational" approach to help the depressive understand his feelings. The therapeutic aim is to provide the patient with a time perspective. This involves the suggestion to the patient that his depression will reliably disappear with the passage of time, and provides for an analysis

of present and future committments to incentives which may be maladaptive (i.e. realistically beyond the patient's reach). This approach suggests the construction of reasonable goals for the patient, thereby increasing his expectancy for incentive-achievement. Klinger argues that this approach should reduce anxiety, increase instrumental behavior, and provide a release from depression.

5. THE BEHAVIORAL VIEW

Depression, according to behavioral theorists, is the result of reinforcement deprivation, which often results from the inability of the individual to behave in an adaptive manner. C. B. Ferster's "Functional Analysis of Depression" appears to be representative of the behavioral view, and hence will be presented below.

Ferster (1973) argued that, in general, a behavioral approach is useful in objectifying knowledge of human behavior that is discovered in clinical and experimental settings. By defining behaviors objectively, basic behavioral processes can be applied "to discover the kinds of circumstances that increase or decrease the frequency of particular ways of acting" (p.857). Such an account of the phenomenon of depression can provide a framework for experiments that measure complex clinical data. The establishment of the functional relation between the patient's behavior and its consequences can provide clues to effective therapeutic intervention. In short, behavior, rather than cognitions, serves as the focus for the analysis of depression.

Ferster suggested that depression can be described as the reduced

frequency of adjustive behavior. He cited the high frequency of escape and avoidance behaviors as evidence for his description. He further argued that the reduced frequency of some activities in the patient's repertoire may reduce the effectiveness of reinforcers in other areas. However, avoidance behaviors are themselves reinforcing in that they terminate aversive stimulation. As a result, these behaviors tend to interfere with the acquisition of new behaviors which could be subject to positive reinforcement.

Ferster accounts for the passivity of the depressed individual by arguing that the bulk of his behavior is likely to be derived from commands or other's initiatives, rather than from freely emitted activities. Thus, passivity appears to be connected to the preponderance of aversive control applied by others and the absence of positive control derived from the individual's behavioral repertoire. In effect, while the active person engages in a reciprocal relationship with the environment, the passive, depressed person simply reacts to the environment. An active repertoire consists of behaviors that remove, alter and cope with aversive stimulation. A passive repertoire simply allows for escape and does not enable the individual to achieve a degree of mastery in unpleasant situations.

Ferster suggested that the basic processes which describe depressive behavior are: a) the reinforcement of behavior which explains its origin and cause; b) its continued maintenance despite infrequent or intermittent reinforcement; and c) its selective control by various parts of the physical and social environment that signal the occasions when it can be reinforced.

Reinforcement

The depressive acts so inappropriately that he experiences a low frequency of positive reinforcement. Ferster argues that the patient cannot observe the environment accurately and hence much of his behavior will be maladaptive. Patients' behaviors are not appropriate to the changing circumstances in the environment. In addition, the depressive is unlikely to explore the environment and thereby expand his repertoire. This is highly related to the reasons why low frequency behaviors associated with depression are maintained.

Maintenance

Ferster (1973) suggested that depression represents a developmental halt due to the fact that "contingencies in the environment are not consistent with the person's currently emitted behavior" (p. 862). This failure to adapt becomes greater because the lack of contact (via passivity) with the current environment reduces the frequency of behavior and prevents the further development of the repertoire. Thus, low frequency behaviors are maintained and pose obstacles to the successful treatment of depression.

Factors in the environment which affect behavior

Ferster believes that factors in the environment which provide for only intermittent reinforcement will usually reduce the amount of behavior generated by reinforcement. However, the kind of intermittency will affect how frequently an act occurs. For example, schedules of reinforcement requiring large amounts of behavior to produce relevant change in the environment are those most susceptible to loss (e.g. FR as opposed to VI

schedules of reinforcement). Thus, the depressed individual is unlikely to engage in a long series of behaviors to achieve a goal. Additionally, Ferster argues that behavior may be signalled or suppressed as a result of dramatic changes in the environment. The death of a loved one will remove a powerful source of reinforcement and may be associated with a decline in the frequency of behavior. Likewise, periods of excessive stimulation may evoke sudden bursts of behavior.

In summary, the behavioral analysis of depression focuses on the reduced frequency of adaptive behaviors due to environmental contingencies, lack of an adequate repertoire, or the distortion of events in the environment. The behavioral treatment of depression, then, involves the acquistion of mastery behaviors. For a more detailed account of the behavioral view, the reader is encouraged to read Davidson (1976).

The general focus for the behavioral treatments for depression is to help patients acquire skills or behaviors which will result in positive reinforcement. It is presumed that once an individual engages in satisfying instrumental activity, he will reestablish control over troublesome sectors of his environment and will experience a more normal and pleasant affective state. Behaviors which are accompanied by depressive affect are examined and, if appropriate, attempts are made to either modify or extinguish them. Otherwise, therapeutic intervention is often centered around the training of the patient in whatever skills are required to effect successful, reinforcing, interaction with the environment.

1. Ferster's Treatment Approach

Ferster suggests that the depressive's passivity is related to both his lack of verbal activity and his confusion about the social environment. He argues that therapeutic effort should initially be directed toward increasing the patient's verbal activity. Persistent verbal behavior is said to be important insofar as it implies (via increased social interaction) a reasonable understanding of how the environment works. "An accurate view of how the environment works will husband behavior for those occasions when it can be effective and prevent acts that can cause trouble because they occur in inappropriate occasions" (p.867). By observing the environment and describing it verbally, the patient (with the therapist's help) should be able to recognize what behaviors are appropriate in specific situations and perform (and be reinforced) accordingly.

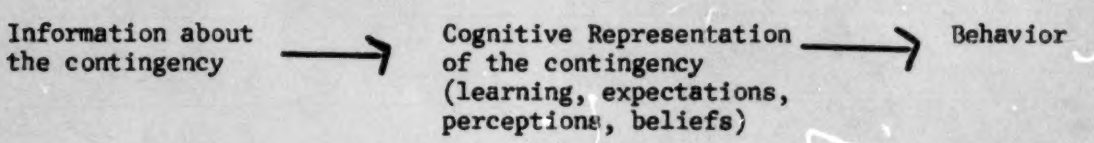
6. THE LEARNED HELPLESSNESS (1h) VIEW

Several investigators (Overmeir & Seligman, 1967; Seligman & Maier, 1967) have recently reported deficits in avoidance behavior in animals receiving inescapable shock. This effect has become known as the "learned helplessness" paradigm and is usually associated with Martin Seligman

Seligman's Model of human behavior

In general, Seligman suggests that helplessness in animals and depression in man are caused by the organism's learning that responding and reinforcement are independent. More specifically, people who believe that the responses they emit will have no effect on reinforcement are said to be helpless or depressed, and exhibit several symptoms (lowered

initiation of voluntary responses, negative cognitive set, lowered aggression, loss of appetite, physiological changes, time course).


Information about the contingency
Cognitive Representation of the contingency (learning, expectations, perceptions, beliefs)
Behavior

Both men and animals begin with information about the contingency of outcome upon response. This information is a property of the environment, rather than one of the perceiver. For example, experimentally induced shock is either escapable or inescapable. However, the information about the contingency is processed cognitively and is labelled "learning," or "perceiving", or "expecting", etc. In the helplessness--depression case the learnings, expectancies, etc. are that response and outcome are independent. In effect, the cognitive processes mediate behavior.

Seligman (1975) argues that "the forced exposure to the fact that responding produces reinforcement is the most effective way of breaking up learned helplessness" (p.99). This contention is derived from his experience with helpless dogs. The only way Seligman could get the helpless, passive dogs to learn that by jumping the barrier in the shuttle box they could escape experimental shocks was to drag them (by leash) from the shock side to the escape side of the shuttle during the shock trials. After many such trials (up to 200!) the dogs finally learned that jumping the barrier would lead to escape and began to perform that behavior on their own. For ethical and practical reasons such a

dramatic use of therapeutic force may be inappropriate for the treatment of reactive depression. In view of this, Seligman advocates such behavioral interventions as "graded-task" treatments, which successively approximate a target or criterion behavior, assertion training, and any cognitive approach which will effect a change toward the positive in the depressive's cognitive set. Seligman would favor any treatment which would manipulate the patient's expectancies and motivation toward instrumental coping responses. A rather strange example of a treatment for 1h is the "Tuscaloosa Plan," in which the patient is harrassed until he elicits an angry response which serves to remove him from an aversive situation. The use of this technique appears highly risky and requires additional research to warrant its common practice.

7. THE PHYSIOLOGICAL VIEW

This manual's focus is the psychological management of depression. While pharmacotherapy has proven somewhat effective in ameliorating the physical symptoms of depression, it is beyond the scope of this paper.

Weiss et.al.(1975) position is worth mentioning. They posit that physiological mechanisms may mediate, rather than cause, behavioral/affective disorders. Weiss suggested that a lack of control over stressful situations may induce depletions of certain neurotransmitters, which in turn may mediate emotional and behavioral disturbances. Weiss et. al. offer the following model of behavioral disorder which bears on the question of how psychological variables (e.g. perceived/actual inescapability from a threatening situation) affect physiological

responses. This is shown in the diagram below as the influence of (A) on (B):

(A)	(B)	(C)
Psychological variables in stressful situations	Physiological changes	Behavioral changes
Dfces. in ability to control a stressor	Dfces. in: gastric lesions food/water intake body weight steroids brain NE	Dfces. in avoidance-escape behavior

Weiss et. al. suggest that different physiological changes (B) can arise from psychological variables in stress situations (A), and mediate behavioral changes (C). In this model, it is potentially possible to observe how significant psychological factors lead to behavior change via physiological mediation.

In summary, the theories most frequently account, directly or indirectly, for: negative expectancy, dejected mood, behavioral deficits, retarded physical activity, loss of libido and appetite and motivational deficits. A majority of the theories acknowledge faulty cognitions, passivity and avoidance as manifestations of depression.

Depression Workshop

Based on the review of depression, a workshop was designed to help students manage depression and stress. The workshop is based on the same assumption of Ribner and Ginn (1975), "That most depressions college students experience are set off by some external event (failure, loss, rejection, etc) and are maintained both by secondary gains (e.g. attention from peers) and by the students' belief in their own helplessness to alleviate the situation." This workshop is not intended to replace individual therapy, but can be used as a productive adjunct to it. The experience is deliberately structured and didactic in nature, in the premise that an orderly approach to the acknowledgment and understanding of symptoms of depression will establish the bases for therapeutic improvement. What follows is a suggested outline which attempts to encompass the major variables relative to depression. It is our hope that our workshop leaders will be flexible in the delivery of the workshop in order to meet individual client needs.

This workshop is held for 2 sessions of 3 hours each. Enrollment is limited to 8 students who are referred by their individual counselors. This workshop requires 2 staff members to serve as co-leaders.

Session 1

A. Focus

The focus of this workshop is to provide information relative to the causes and nature of depression; to offer a variety of experiences and didactic material to assist the client in handling the more debilitative effects of depressions. The workshop will provide an atmosphere in which clients can understand their symptoms and begin to work constructively to counteract them.

B. Introduction of group members

How all group members share. 1) Who they are; 2) Why they came to the workshop; 3) Identification of expectations. This helps to break the ice and gets depressed clients to speak about themselves.

C. Group Leaders Expectations

By the end of the workshop it is expected that clients will (if they choose) be able to better understand the causes of their depressions and be better able to take more responsibility for their symptoms and to take with the depressions more effectively. It is also expected that the members be willing to take active steps (as a function of the workshop) to counteract their depression. Part of the responsibility of the group leader is to detect and confront any member who is receiving secondary gain from their depressed state! A paraphrasing of the above should be shared with the group members.

D. Definition of Depression

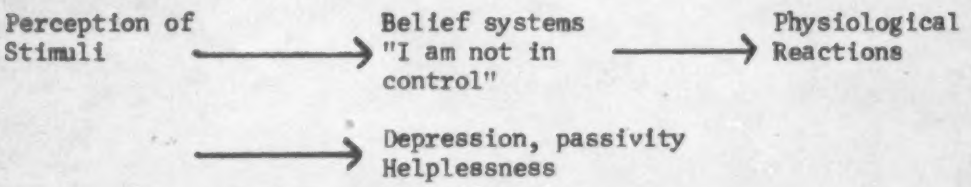
Lecturette on definition and nature of depression; see manual under "symptoms of Depression," pp. 2-7. This should be individually prepared by particular group leaders in order to fit their own styles.

E. Causes for Depression

Depression is triggered by a variety of effects. Listed below are some major causes. It is suggested that the leaders explore some or all of the causes stated below based on the make-up of the group. (i.e. as a re-action to loss, as a reaction to unfulfilled expectancies, as a reaction to profound stress, as a function of a belief that we are unable to control the major outcomes and sources of reinforcement in our lives); lead into discussion of the learned helplessness explanation of depression.

F. Broad definition and explication of learned helplessness

(lecturette to be shared with group; see manual)



G. How depression is maintained

lecturette on:

1. Secondary gain (sympathy, affection, etc.) that occurs from being depressed.
2. Explanation of Ellis' Theory of Emotional Disorders A-B-C Model (See Ellis, 1962)
3. Listing some of Ellis' Irrational Beliefs.
4. Have group process what irrational beliefs they may have and teach them how to counter them by identifying and using rational self-statements.

H. Homework for group members: Continue to identify negative self-statements to be shared with group next session. Have members read Beck & Greenberg's (1974) article, Coping with Depression (available from the Institute for Rational Living, Inc., 45 E. 65th Street, New York, New York 10021).

Session 2

A. Goals

1. To ensure client understanding of material presented in first session.
2. To help them share their own sense of the roots of depression with each other based on material provided in the first session.
3. To help them share their own adaptive responses to depression.
4. To provide them with additional means of counteracting depressed feelings.

B. Division of homework assignment

Themes of discussion:

1. Identify negative self-talk which they became aware of during the interview.
2. Have group brainstorm ways to combat negative self-talk.
3. Using Beck's article, have group identify cognitive inaccuracies; assist clients in challenging faulty assumptions; and generate more reasonable interpretations of reality, as well as more rational expectations.

C. Gestalt Exercise
(Ribner and Ginn, 1975)

The theme of this exercise is to have clients recognize and deal with feelings of hurt, anger, resentment, etc., and to tune into physical feelings, and to identify self-defeating helplessness. (See Appendix 1)

D. Relaxation Exercise (if time allows)

To have clients gain control over their bodies. (See Appendix 2, Jacobson, 1938)

E. Summary

Depression is an inevitable fact of life. As such, it is a learned phenomenon. Therefore, depression can be unlearned by analyzing the relationship between feelings, thoughts, and behavior. It seems important, given the amount of stress already present in the college student's world, that they be fair with themselves and others in terms of expectations.

The summary lesson of this experience is that the depressed person must accept responsibility for his feelings, thoughts, and behavior. The acceptance of this responsibility will hopefully provide enough motivation to alter any depression inducing disposition the client has. By getting the client involved through understanding and action, we are combatting helplessness.

Appendix 1*

Close your eyes and think of your depression. Focus your attention on it and seek to be more aware of it in detail.....Pay particular attention to feelings of pain and tension....Now become this symptom. As your depression, what are you like? What are your characteristics, and what do you do to this person?...Now talk to this person and tell the person how you make him or her feel....Now become yourself again and talk back to this symptom....What do you answer?....What is going on between you?....Now become the depression again and continue the dialogue....Tell this person what you do for him or her....In what way are you useful?....How do you make his or her life easier in some way? ....What else do you help the person avoid?

Become your depression again and identify with it....Now continue to be this symptom and talk to the people in your environment. Talk to parents, friends, boss, roommates - anyone that you affect - and tell them all how you affect them....What do they do because of you?....Tell them what you do to them and see what they reply....Now become yourself again and say the same things to these people as yourself. Take responsibility for what you do. For example, "I use my depression to make you do things I don't want to do," or whatever your situation....

* Adapted from Steven (1971) by Ribner and Ginn (1976)

Appendix 2

RELAXATION TECHNIQUES

RELAXATION OF ARMS
(time: 4-5 min.)

Settle back as comfortably as you can. Let yourself relax to the best of your ability....Now, as you relax like that, clench your right fist, just clench your fist tighter and tighter, and study the tension as you do so. Keep it clenched and feel the tension in your right fist, hand, forearm...and now relax. Let the fingers of your right hand become loose, and observe the contrast in your feelings....Now, let yourself go and try to become more relaxed all over.... Once more, clench your right fist really tight...hold it, and notice the tension again.... Now let go, relax; your fingers straighten out, and you notice the difference once more.... Now repeat that with your left fist. Clench your left fist while the rest of your body relaxes; clench that fist tighter and feel the tension...and now relax. Again enjoy the contrast.... Repeat that once more, clench the left fist, tight and tense.... Now do the opposite of tension--relax and feel the difference. Continue relaxing like that for a while.

Clench both fists tighter and tighter, both fists tense, forearms tense, study the sensations...and relax; straighten out your fingers and feel that relaxation. Continue relaxing your hands and forearms more and more.... Now bend your elbows and tense your biceps, tense them harder and study the tension feelings...all right, straighten out your arms, let them relax and feel the difference again. Let the relaxation develop .... Once more, tense your biceps; hold the tension and observe it carefully....Straighten the arms and relax; relax to the best of your ability.... And now relax your arms back into a comfortable position. Let the relaxation proceed on its own. The arms should feel comfortably heavy as you allow them to relax...concentrate on pure relaxation in the arms without any tension. Get your arms comfortable and let them relax further and further. Continue relaxing your arms even further. Even when your arms seem fully relaxed, try to go that extra bit further; try to achieve deeper and deeper levels of relaxation.

RELAXATION OF FACIAL AREA WITH NECK, SHOULDERS, AND UPPER BACK
(time: 4 5 min.)

Let all your muscles go loose and heavy. Just settle back quietly and comfortably. Wrinkle up your forehead now; wrinkle it tighter.... And now stop wrinkling your forehead, relax and smooth it out. Picture the entire forehead and scalp becoming smoother as the relaxation in creases.... Now frown and crease your brows and study the tension.... Let go of the tension again. Smooth out the forehead once more.... Now, close your eyes tighter and tighter...feel the tension...and relax your eyes. Keep your eyes closed, gently, comfortably, and notice the relaxation.... Now clench your jaws, bite your teeth together; study the tension throughout the jaws.... Relax your jaws now... Appreciate the relaxation .... Feel the relaxation all over your face, all over your forehead and scalp, eyes, jaws, lips, tongue and throat. The relaxation progresses further and further.... Now attend to your neck muscles. Press your head back as far as it can go and feel the tension in the neck. Let your head return forward to a comfortable position, and study the relaxation. Let the relaxation develop.... Shrug your shoulders, right up. Hold the tension.... Drop your shoulders and feel the relaxation. Neck and shoulders relaxed.... Shrug your shoulders again. Feel the tension in your shoulders and in your upper back.... Drop your shoulders once more and relax. Let the relaxation spread deep into the shoulders, right into your back muscles; relax your neck and throat, and your jaws and other facial areas as the pure relaxation takes over and grows deeper... deeper...deeper.

RELAXATION OF CHEST, STOMACH AND LOWER BACK
(time: 4-5 min.)

Relax your entire body to the best of your ability. Feel that comfortable heaviness that accompanies relaxation. Breathe easily and freely in and out. Notice how the relaxation increases as you exhale...as you breathe out just feel that relaxation.... Now breathe right in and fill your lungs; inhale deeply and hold your breath. Study the tension .... Now exhale by letting the walls of your chest grow loose and push the air out automatically...Continue relaxing and breathe freely and gently. Feel the relaxation and enjoy it.... With the rest of your body as relaxed as possible, fill your lungs again. Breathe in deeply and hold it again.... That's fine, breathe out and appreciate the relief... Just breathe normally. Continue relaxing your chest and let the relaxation spread to your back, shoulders, neck and arms. Merely let go... and enjoy the relaxation.... Now let's pay attention to your abdominal muscles, your stomach area. Tighten your stomach muscles, make your abdomen hard. Notice the tension.... And relax. Let the muscles loosen and notice the contrast... Once more, press and tighten your stomach muscles. Hold the tension and study it.... And relax. Notice the general feeling of well-being that comes with relaxing...Now tense your stomach, feel the tension.... Now relax again. Continue breathing normally and easily.... Now pull your stomach in and hold the tension... hold the tension...now relax your stomach fully. Let the tension dissolve as the relaxation grows deeper. Each time you breathe out, notice the rhythmic relaxation both in your lungs and in your stomach. Notice and let go of all contractions anywhere in your body.

RELAXATION OF HIPS, THIGHS AND CALVES FOLLOWED BY

COMPLETE BODY RELAXATION
(about 5 min.)

Let go of all tensions and relax.... Now flex your buttocks and thighs. Flex your thighs by pressing down your heels as hard as you can.... Relax and note the difference.... Flex your thigh muscles again. Hold the tension....Relax your hips and thighs. Allow the relaxation to proceed on its own.... Press your feet and toes downwards, away from your face, so that your calf muscles become tense.... Now relax...allow the relaxation to proceed on its own.... Once again press your feet and toes downwards, away from your face, so that your calf muscles become tense. Study that tension.... Relax your feet and calves.... Keep relaxing for a while....Now let yourself relax further all over. Relax your feet, ankles, calves and shins, knees, thighs, buttocks and hips. Feel the heaviness of your lower body as you relax still further....Now spread the relaxation to your stomach, waist, lower back. Let go more and more. Feel that relaxation all over. Let it proceed to your upper back, chest, shoulders and arms and right to the tips of your fingers. Keep relaxing more and more deeply. Relax your neck and your jaws and all your facial muscles. Keep relaxing your whole body like that for a while. Let yourself relax.

Now you can become twice as relaxed as you are merely by taking in a really deep breath and slowly exhaling. Breathe in deeply and feel yourself becoming heavier. Take in a long, deep breath and let it out very slowly....Feel how heavy and relaxed you have become.

Now, your whole body becomes progressively heavier, and all your muscles relax. Let go more and more completely. We shall give your muscles individual attention. Relax the muscles of your forehead. (Pause 5-10 sec.) Relax the muscles of the lower part of your face. (Pause 5-10 sec.) Relax the muscles of your jaws and those of your tongue. (Pause) The more you relax, the calmer you become. (Pause) Relax the muscles of your neck. (Pause) Let all the muscles of your shoulders relax. Just let yourself go. (Pause) Relax the muscles of your trunk. (Pause) Relax the muscles of your lower limbs. Let your muscles go more and more. You feel so much at ease and so very comfortable. Just continue relaxing like that.....

(End) I will count backwards from four to one. When I get to one you will get up. You will feel fine and refreshed, wide awake and calm.

Bibliography

Beck, A.T. Depression. Philadelphia: University of Pennsylvania Press, 1967.

Beck, A. Tand Greenberg R.L. Coping with depression. Institute for Rational Living, 1974.

Bibring, E. The mechanism of depression. In P. Greenacre (Ed.), Affective Disorders. New York: International Universities Press, 1953.

Davidson, P.O. The behavioral management of anxiety, depression, and pain. New York: Brunner/Mazel Publishers. 1976.

Ellis, A. Reason and emotion in psychotherapy. New York: Lyle Stuart, 1962.

Ferster, C. A functional analysis of depression. American Psychologist, 1973, 28, 857-870.

Hiroto, D., and Seligman, M. Generality of learned helplessness in man. Journal of Personality and Social Psychology, 1975, 31, 2.

Jacobson, E. Depression: Comparative Studies of normal, neurotic and psychotic conditions. New York: International Universities Press, 1971.

Jacobson, E. Progressive Relaxation. Chicago: University of Chicago Press, 1938.

Klinger, E. Consequences of committment to and disengagement from Incentives. Psychological Review, 1975, 82, 1, 1-25.

Kraeplin, E. Manic-depressive insanity and paranoia, 1913. In Textbook of Psychiatry translated by Berelay, R.M. Edinburgh, Livingstone.

Meyer, A. The problems of mental reaction types, 1908. In the Collected papers of Adolph Meyer. Baltimore, Maryland: John Hopkins Press, 1951.

Overmeir, J., and Seligman, M. Effects of inescapable shock upon subsequent escape and avoidance learning. Journal of Comparative and Physiological Psychology, 1967, 63, 23-33.

Rotter, J. Social Learning and Clinical Psychology. Englewood Cliffs, New Jersey: Prentice-Hall, 1954.

Ribner, N.and Ginn, R. Overcoming and managing depression. Personnel and Guidance Journal, 1975, 54(3).

Seligman, M. Helplessness: depression, development and death. San Francisco: Freeman, 1975.

Seligman, M., and Maier, S. Failure to escape traumatic shock. Journal of Experimental Psychology, 1967, 74, 1-9.

Bibliography

Stevens, J. Awareness: Exploring, experimenting, experiencing. Lafayette, Calif.: Real People Press, 1971.

Weiss, J., Glazer, H., and Pohorecky, L. Coping behavior and neurochemical changes in rats. Paper presented at the Kittay Scientific Foundation Conference, March, 1975; to be published in Relevance of the Psychopathological Animal Model to the Human. New York: Plenum Press.